UPDATED HISTORY

Date: ____________

Patient Name: ______________________________ DOB: ____/____/_______ Age: ________

Please fill out the following information pertaining to today's office visit:

Reason for today's visit? ____

____

Date of last menstrual period: _____/_____/_____ How often are your periods? Every __________ days

How long do your periods last? __________ days Is your menstrual flow: Light / Moderate / Heavy

Any changes in current medications since last visit? (strength, dosage—include supplements)

Started taking: ____

Stopped taking: ____

Any changes to family history since last visit? Yes / No If yes, please explain:

____

Any surgeries since last visit? Yes / No If yes, please explain what surgery and when:

____

Do you **CURRENTLY** have any of the following complaints **TODAY**?

General: None:___ Weight gain:___ Weight loss:___ Night Sweats:___ Fever:___ Fatigue:___

GI: None:___ Nausea:___ Vomiting:___ Diarrhea:___ Constipation:___ Blood in Stool:___ Hemorrhoids:___

Urinary: None:___ Pain with urination:___ Leaking urine:___ Urgency:___ Frequency:___

Genital: None:___ Heavy periods:___ Painful periods:___ Irregular periods:___ Pelvic pain:___ Pain w/ intercourse:___ Genital lesion:___ Vaginal dryness:___ Vaginal discharge:___ Vaginal itching:___ Vaginal odor:___ Vaginal pain:___

Breast: None:___ Nipple discharge:___ Breast pain:___ Lump:___ Skin Changes:___

Psychiatric: None:___ Depression:___ Anxiety:___ Crying:___ Mood swings:___

Endocrine: None:___ Hot Flashes:___ Male pattern hair growth:___ Decreased sex drive:___

Heme/Lymph: None:___ Easy bruising/bleeding:___ Calf tenderness:___ Enlarged lymph nodes:___

Skin: None:___ Acne:___ Rash:___ Skin Lesions:___ Dry skin:___

______________________________ ______________

Signature Date